SAMHSA-HRSA
CENTER for INTEGRATED
HEALTH SOLUTIONS

Team Based Care

Jeff Capobianco, PhD
National Council for Behavioral Health

Setting the Stage:
Today's Moderator

Madhana Pandian
Associate
SAMHSA-HRSA Center for Integrated Health Solutions

SAMHSA HRSA Health Resources & Services Administration
integration.samhsa.gov

Slides for today's webinar will be available on the CIHS website:

www.integration.samhsa.gov

Under About Us/

Innovation Communities 2017

To participate

Use the chat box to communicate with other attendees

integration.samhsa.gov

Disclaimer: The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), or the U.S. Department of Health and Human Services (HHS).

Setting the Stage

Jeff Capobianco, PhD, LLP
Sr. Consultant National Council for Behavioral Health

Overview of Today's Webinar

- What Have I Signed-up For?: Review of the Innovation Community Objectives
- Getting to Know Each Other: Who are your IC Colleagues?
- Calendar of Events
- Review the Organizational Self-Assessment Tool & Work Plan
- Wrap-up Questions

What is an Innovation Community?

- Intensive four month rapid improvement process
- Distance-learning infrastructure:
  - Webinars
  - Conference Calls
  - Group Emails
  - Website
- Subject matter & peer-based learning approach

Getting to Know Each Other!

- Which States are Represented?
- What kind of Market Urban/Suburban/Rural/Frontier?
- What Services are Provided?
- Who is being Served?
- Aggregate PIHC Organizational Self Assessment Scores?

States Represented

	Organization Name:	State
1	Heartland Health Outreach, Inc.	IL
2	Whiteriver PHS Indian Hospital	AZ
3	Development Centers	MI
4	Northeast Guidance Center	MI
5	Spectrum Healthcare Group	AZ
6	The Guidance Center	MI
7	Mid-Erie Mental Health Services, Inc	NY
8	Southwest Behavioral Health	AZ
9	Integral Care	TX
10	Adirondack Health	NY
11	Tarzana Treatment Centers, Inc.	CA
12	Seven Hills Foundation	MA
13	Fetter Health Care Network	SC
14	Logan Mingo Area Mental Health, Inc.	WY
15	San Luis Valley Behavioral Health Group	CO
16	Sequel Youth and Family Services	AL

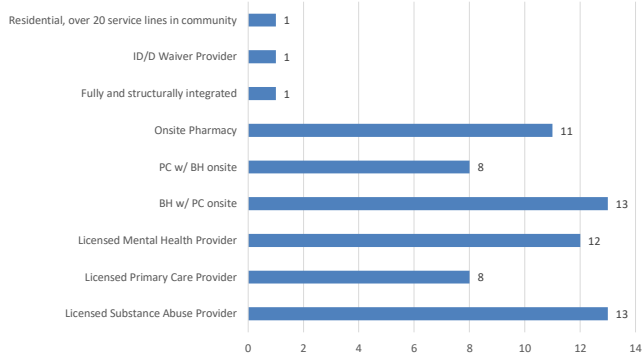
Share out!

Please have one person from each team describe what you would like to achieve during this innovation community.

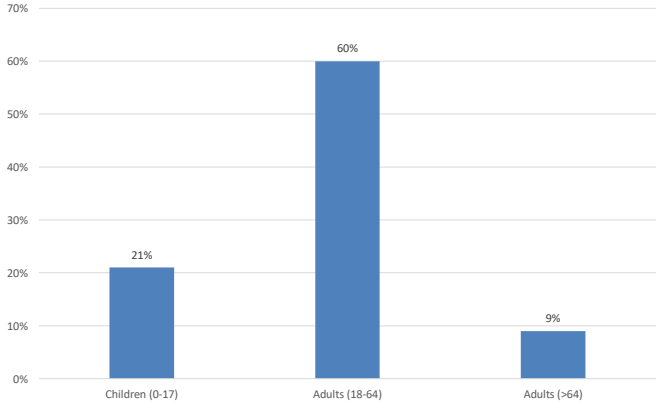
Areas Served

Urban	7
Rural	7
Frontier	0
Suburban	1
Other	1

Services Offered by Participating Organizations:



Who Are you serving? Percentage Served Across Participating Organizations



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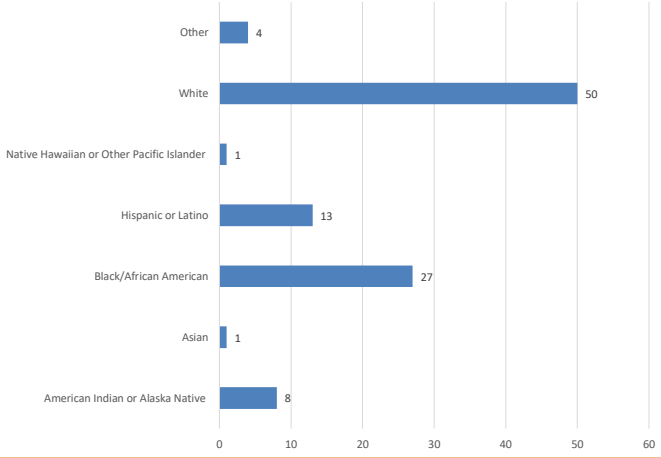


IC Learning Objectives

- Learn best practice approaches to Team Base Care
- Successfully develop and implement a work plan specific to the need areas identified in your organizational self-assessment findings
- Hear from Subject Matter Experts on their work, models, and lessons learned
- Utilize a shared learning model to help one another toward a common goal

What is Team Based Care?

Team-based care is defined by the National Academy of Medicine (formerly known as the Institute of Medicine) as "...the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient - to accomplish shared goals within and across settings to achieve coordinated, high-quality care."

- Naylor MD, Coburn KD, Kurtzman ET, et al. Inter-professional team-based primary care for chronically ill adults: state of the science. Unpublished white paper presented at the ABIM Foundation meeting to Advance Team-Based Care for the Chronically Ill in Ambulatory Settings. 2010 March 24-25; Philadelphia, PA.
- Mitchell P, Wynia R, Golden B, et al. Core principles and values of effective team-based health care. Discussion Paper. Washington, DC: Institute of Medicine; 2012. https://www.nationalahec.org/pdfs/VSRT-Team-Based-Care-Principles-Values.pdf (link is external).
- Okun, S, Schoenbaum S, Andrews D, et al. Patients and health care teams forging effective partnerships. Discussion Paper. Washington, DC: Institute of Medicine; 2014. https://www.accp.com/docs/positions/misc/PatientsForgingEffectivePartnerships%20-%20IOM%20discussion%20paper%202014.pdf (link is external).

Primary Sources for our TBC IC

1. National Committee on Quality Assurance (NCQA) Criteria/Standards regarding Team Based Care:

- Patient-Centered Medical Home (Core Requirement)
- Patient-Centered Specialty Program (Core Requirement)

2. Cambridge Health Alliance Model of Team-Based Care Implementation Guide & Toolkit

3. Essential Elements of Effective Integrated PC & BH Teams

4. Amy Edmondson's work at the Harvard Business School

Relevance of PCSP (or PCMH?) to CCBHCs

CCBHC Criteria

- Staffing
- Availability and Accessibility of Services
- ***Care Coordination***
- Scope of Services
- Quality and other Reporting
- Organizational Authority and Accreditation

PCSP Standards

- ***Provide Access and Communication***
- Track and Coordinate Referrals
- Identify and Coordinate Patient Populations
- Track and Coordinate Care
- Plan and Manage Care
- Measure and Improve Performance

PCMH

- Enhance Access and Continuity
- ***Team Based Care***
- Care Coordination and Transitions
- Population Health Management
- Care Management and Support
- Performance Measurement and Quality Improvement

Model Components Vary in Difficulty when it comes to Implementation

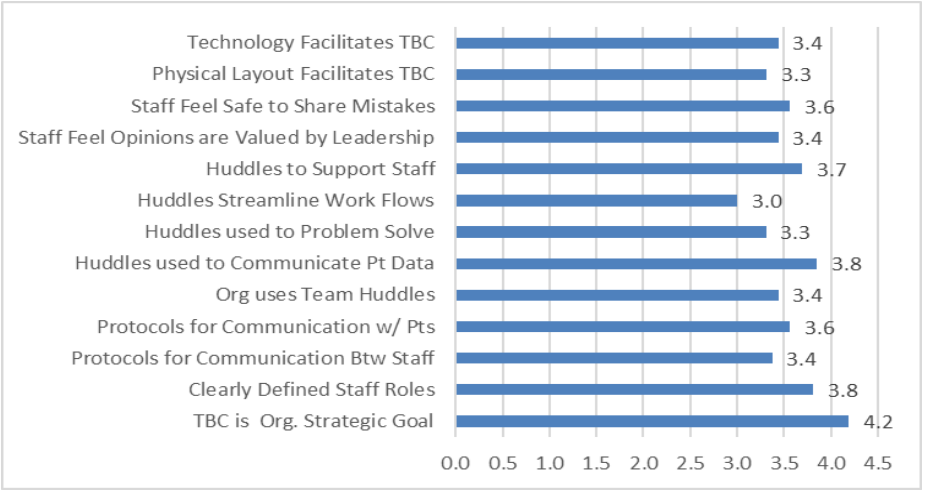
Implementing discrete/structural model components was easier than changing roles and work patterns to use them.

For example, many practices implemented disease registries, but were unable to reconfigure work processes to use them effectively for population management.

Same-day scheduling and e-prescribing were far easier than developing team based care and population management.

Source: Paul A. Nutting, see http://www.slideserve.com/kobe/the-patient-centered-medical-home-implications-for-health-policy-and-workforce-development

Organizational Self-Assessment Avg. Scores (N=14 orgs.)



1=Strongly Disagree 2=Disagree 3=Mixed 4=Agree 5=Strongly Agree

Linking Your Org Self Assessment Scores to your IC Work Plan

- The OSA was designed to provide new perspectives and organization on the work you need to do to become more Integrated
- Unpacking your scores can lead to clear steps your organization can take to develop and execute a work plan.

Work Plan Development

Every IC member must develop a work plan targeting 1-3 goals that are achievable by the end of April 2018.

Using a Stretch & SMART approach to setting goals is a useful approach.

Common Work Plan Components

1. Charge from Leadership
2. Communication Plan
3. Goals/Objectives/Tasks
4. Responsible Lead Staff
5. Supporting Staff
6. Measurable Target Outcome(s)/Deliverable
7. Timeline & Due Date/Completion Date
8. Resources Required

Sample Work Plan Elements

1. **Goal:** Team Huddles
2. **Objective1:** Determine best fit format for huddles (time of day, frequency, participants, format)
3. **Tasks:** Sally R & Fred J to analyze need, best time of day for fit, participants and presentation
4. **Responsible Lead Staff:** Fred J.
5. **Supporting Staff:** Sally R., Jim J., Erika P.
6. **Outcome(s):** Team members will have a format and expectation for huddles
7. **Date/Completion Date:** March 1, 2018
8. **Resources Required: A**nalysis of workflow to determine format 1 hour, write up of workflow 1 hour, presentation for buy in 30 minutes

What we will be doing for the next 4 Months!

- Monthly Webinars
- Group Emails
- Coaching Calls
- Open Door Fridays
- Homework Assignments
- Participant IC Report Out
- Evaluation Activities

Webinar Schedule

Tuesday, January 9th 1-2:30PM EST

Tuesday, February 13th 1-2:30PM EST

Thursday March 22nd, 1-2:30pm EST

Tuesday April 17th 1-2:30pm EST

Homework

- Convene Core Implementation Team (CIT)
- Finalize Work Plan for Submission/Discussion on Coaching Call
- Required Reading Assignments: HOLD
- Optional Reading Assignment: HOLD

Questions/Discussion

Contact information:

Jeff Capobianco
Jeffc@thenationalcouncil.org
734.604.2591